



VIA ELECTRONIC SUBMISSION

September 11, 2026

The Honorable Dr. Mehmet Oz
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW Room 445-G
Washington, DC 20201
Attention: CMS-1848-P

Re: CY 2027 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; and Medicare Prescription Drug Inflation Rebate Program Proposed Rule (RIN 0938-AV82)

Dear Administrator Oz,

The Peterson Center on Healthcare (the Center) appreciates the opportunity to comment on select provisions of the Centers for Medicare & Medicaid Services' (CMS) CY 2027 Medicare Physician Fee Schedule proposed rule.

The Center is a nonprofit, nonpartisan organization dedicated to making higher-quality, more affordable healthcare a reality for all Americans. We are working to create a more efficient and cost-effective healthcare system in the United States by finding and promoting innovative solutions that improve quality and lower costs. To advance these goals, we have prioritized efforts to improve data transparency, stimulate competitive healthcare markets, and promote the use of high-value health technology—including launching the Peterson Health Technology Institute (PHTI), which is an independent, self-funded organization dedicated to accelerating the adoption of healthcare technologies that improve health and lower costs.

We share CMS's deep commitment to ensuring that Medicare payment for services reflects the value of the services provided. Outcome-based payment models are the most appropriate way to pay for chronic condition management where there are measurable clinical outcomes. Last year the Center recommended that CMS test an outcome-based payment model for remote monitoring, potentially combining a small base payment with a larger payment tied to patient clinical outcome achievement. We applaud CMS for testing this approach by launching the Advancing Chronic Care with Effective, Scalable Solutions (ACCESS) model—the first large-scale model that aligns payment for technology-enabled care with measurable outcomes.

CMS plays an important role in stimulating ongoing health technology innovation to ensure that older Americans have access to tools that improve their lives, enhance their care experiences, and reduce costs. As the nation's largest purchaser, Medicare coverage, reimbursement, and payment design decisions can drive broader market impact.

To that end, we propose an alternative path for modernizing payment for remote physiologic monitoring (RPM) and remote therapeutic monitoring (RTM) services than what the Agency has

put forth in this proposed rule—one that increases accountability, encourages access to high-value remote monitoring, and generates real-world evidence to inform future outcome-based payment models.

The Center's vision is that all chronic condition management with well-established clinical outcomes should transition to an outcome-based payment model such as ACCESS, regardless of whether the service is delivered by a traditional provider or a technology company.

The shift to outcome-based payment is increasingly urgent as AI fundamentally changes the underlying economics of healthcare delivery. Fee-for-service payment was designed to reimburse discrete services delivered by clinicians; it is poorly suited for technology that can increasingly perform clinical tasks that previously required human labor and expertise. Continuing to pay primarily for the volume of services delivered, rather than value, creates perverse incentives for technology to increase utilization without improving outcomes.

More broadly, CMS should work with Congress to reform the Physician Fee Schedule and provide the flexibility needed to respond to the changing economics of AI-enabled care. Reform should enable CMS to develop and adapt payment approaches that encourage broad participation in outcome-based payment models, support investment in necessary technology and care-delivery infrastructure, and facilitate alignment in outcome measures and payment structures across Medicare and commercial payers. These approaches should ensure that the efficiencies generated by AI translate into improved outcomes, expanded access, and lower costs for patients and the Medicare program.

Our enclosed comments focus on select provisions of the proposed rule including changes to remote monitoring services, care management services, and payment for AI-enabled care.

Summary of Recommendations

Valuation of Specific Codes, Including Potentially Misvalued Codes (PMVC) (Section II.D.)

Coding and Valuation of Remote Monitoring Services

- **CMS should not proceed with the current proposal to only pay for remote monitoring services when clinical staff are direct employees of the billing practitioner or practice, or with the rate cuts as proposed.** These changes effectively prohibit qualified, contracted personnel from furnishing RPM and RTM services and threaten access to high-value health technologies for Medicare beneficiaries, in addition to curbing low-value services.
- **CMS should evolve remote monitoring services to be outcomes-aligned** by: introducing a six-month duration limit with an active redetermination of medical necessity, ensuring similar, viable payment rates across fee-for-service remote monitoring and the ACCESS model, requiring clinical outcome reporting for services, and ensuring a pathway for traditional providers to be paid based on outcomes, as is done in ACCESS, which traditional providers do not have an option for today. Over time, all chronic condition

management with well-established clinical outcomes should transition to an outcome-based payment model.

- **CMS should strengthen the ACCESS model so that it can serve as a primary pathway for evidence-based, technology-enabled chronic condition management for Medicare beneficiaries.** CMS should consider developing new model tracks and introducing risk adjustment or sub-tracks for highly complex patients.
- **CMS must accelerate the transition of technology-enabled services toward outcome-based payment models as AI is increasingly changing the underlying economics of healthcare delivery.** Fee-for-service payment—today's predominant payment model—was not designed for technologies that can perform clinical work that previously required human labor and expertise.

Redesigning Primary Care to Make America Healthy Again (section II.E.)

Care Management Code Family

- **CMS should continue to assess the clinical and economic value of care management services and evolve payment toward greater outcome accountability.** Utilization and spending have grown substantially in Traditional Medicare and as these services become increasingly AI-enabled, they are at increased risk of being inflationary without delivering commensurate value for Medicare beneficiaries.

We appreciate the opportunity to comment on this proposed rule and welcome opportunities to support CMS on any aforementioned topics. For any questions or follow-up, please contact Julia Harris, Senior Director of Policy at jharris@petersonhealthcare.org and Natalie Joyce, Vice President of Advocacy at njoyce@petersonsolutions.org.

Sincerely,



Caroline Pearson

Executive Director, Peterson Center on Healthcare

Valuation of Specific Codes, Including Potentially Misvalued Codes (PMVC) (section II.D.)

Coding and Valuation of Remote Monitoring Services

CMS proposes several policy changes to Medicare payment for remote physiologic monitoring (RPM) and remote therapeutic monitoring (RTM) services. Beginning in CY 2027, CMS proposes to only pay for RPM and RTM services when clinical staff are direct employees of the billing practitioner or practice and impose valuation changes.

In a yet unpublished claims analysis of Traditional Medicare data commissioned by the Center, researchers find that a subset of practices have substantially higher average RPM costs.¹ These higher costs are driven by both longer episode durations (continuous monthly billing of services) and greater billing intensity (more add-on codes billed per month). The most expensive quartile of practices have an average episode cost of \$2,324, an average duration of 17.7 months, and account for over 50% of total RPM spending. In contrast, the bottom quartile of practices have an average episode cost of \$248 and an average duration of only 2.6 months. Yet, there are no large differences in patient age or comorbidities that might explain these differences.

These findings reinforce a longstanding concern: the current payment structure creates no meaningful incentive for providers to stop billing remote monitoring services. The Center's April 2025 report, *Evolving Remote Monitoring: An Evidence-Based Approach to Coverage and Payment*, outlined this problem— some practices deliver remote monitoring services for longer than is clinically necessary despite the available evidence suggesting that remote monitoring has the greatest impact on a patient's health when used for a focused period of active monitoring and management.²

While the Center strongly supports CMS' efforts to strengthen the value of remote monitoring services, we do not believe the path forward is effectively prohibiting qualified contracted personnel from furnishing these services. Contracted vendors provide substantial efficiencies in delivering remote monitoring services through traditional provider partnerships. CMS should continue to permit qualified contracted clinical personnel to furnish remote monitoring services and instead pursue an alternative path for modernizing payment for remote monitoring—one that increases accountability, encourages access to high-value remote monitoring, and generates real-world evidence.

Our recommendations are for CMS to:

1. **Evolve remote monitoring services to be outcomes-aligned** by: introducing a six-month duration limit with an active redetermination of medical necessity, ensuring similar, viable payment rates across fee-for-service remote monitoring and the ACCESS model, requiring clinical outcome reporting for services, and ensuring a pathway for traditional providers

¹ These unpublished findings are from a Peterson Center on Healthcare funded project conducted by researchers at Brown, Columbia, and the Hasso Plattner Institute. The results are also described in their independent public comment letter, which can be found at <https://www.regulations.gov/comment/CMS-2026-2377-9174>

² *Evolving Remote Monitoring: An Evidence-Based Approach to Coverage and Payment*. Peterson Center on Healthcare. April 16, 2025. <https://www.petersonhealthcare.org/news/evolving-remote-monitoring-report/>

to be paid based on outcomes, as is done in ACCESS, which traditional providers do not have an option for today. Over time, all chronic condition management with well-established clinical outcomes should transition to an outcome-based payment model.

2. **Strengthen the ACCESS model so that it can serve as a primary pathway for evidence-based, technology-enabled chronic condition management for Medicare beneficiaries.** CMS should consider developing new model tracks and introducing risk adjustment or sub-tracks for highly complex patients.

Evolve remote monitoring toward an outcome-aligned benefit

Over the past three years, PHTI has assessed nearly 70 health technologies across seven clinical areas, including tools for [hypertension](#) and [musculoskeletal](#) disorders, both of which identified clinically effective RPM and RTM applications, respectively, that provide meaningful improvements in primary health outcomes relative to usual care.^{3,4} Additionally, remote monitoring programs for pregnant patients with [diabetes](#) and [hypertension](#) led to better clinical outcomes during pregnancy and postpartum, including improved glycemic control and blood pressure monitoring.^{5,6}

However, the current fee-for-service payment structure does not consistently distinguish high-value applications from services that may provide little clinical benefit. Remote monitoring can be billed indefinitely, creating a financial incentive to continue services even after the period of active management has ended.

CMS must evolve remote monitoring services to be more accountable and outcomes aligned. Our recommendations, detailed below, include limiting the duration of the benefit, ensuring similar, viable payment rates across fee-for-service and the ACCESS model, introducing clinical outcomes reporting, and ensuring a pathway for traditional providers to be paid based on outcomes, as is done in ACCESS. Each action should be implemented within a reasonable timeframe so as not to unduly burden providers and compromise ongoing patient care.

Limit duration of remote monitoring services to 6 months

[Evidence](#) suggests that remote monitoring has the greatest impact on a patient's health when used by a healthcare provider for a focused period of active monitoring and management.⁷

³ Digital Hypertension Management Solutions. PHTI Health Technology Assessment. November 2024. <https://phti.org/assessment/digital-hypertension-management-solutions/>

⁴ Virtual Musculoskeletal (MSK) Solutions. PHTI Health Technology Assessment. October 2024. <https://phti.org/assessment/virtual-msk-solutions/>

⁵ Syrop C, Wernimont S, Fleener D, Kardos J, Rubenstein L, Andrews J. Redesigned Care Delivery for Insulin-Requiring Diabetes in Pregnancy Improves Perinatal Glycemic Control While Reducing Neonatal Intensive Care Admissions, Length of Stay, and Costs. *Journal of Women's Health*. 2021;30(4):557–568. <https://pubmed.ncbi.nlm.nih.gov/32833565/>.

⁶ Forna F, Gibson E, Miles A, et al. Improving Obstetric and Perinatal Outcomes With a Remote Patient Monitoring Program for Hypertension in a Large Integrated Care System. *Pregnancy Hypertension*. 2024;35:37–42. <https://www.sciencedirect.com/science/article/abs/pii/S2210778923003914>.

⁷ Tang M, Nakamoto CH, Stern AD, Zubizarreta JR, Marcondes FO, Uscher-Pines L, Schwamm LH, Mehrotra A. Effects of Remote Patient Monitoring Use on Care Outcomes Among Medicare Patients With Hypertension: An

However, currently there is no incentive for a provider to end a patient's remote monitoring after stabilization is achieved (or even to use digital solutions to ensure appropriate patient outcomes).

One of the [highest-impact use cases](#) for digital health technologies is leveraging digital solutions to onboard, adjust, and stabilize patients with high blood pressure to their medication regimen.⁸ Some digital solutions for the management of hypertension integrate dedicated virtual care teams to monitor patients' blood pressure and adjust medications quickly, which helps achieve faster blood pressure control than usual care. Digital remote monitoring solutions focused on medication management were found to meaningfully reduce systolic blood pressure more quickly than in usual care. However, once patients stabilize on their new medication regimen and have lowered their blood pressure, ongoing monitoring becomes less valuable. This suggests that remote monitoring codes should be time-limited to the period where the evidence supports active management of a patient.

The Center recommends that CMS limit remote monitoring codes to 6 months with the opportunity to extend if there is continued medical necessity. There are precedents for medical necessity verification for durable medical equipment that can be analogues to this approach. For example, CMS requires provider attestation to continue Continuous Positive Airway Pressure (CPAP) therapy coverage past the initial 12-week trial period. Providers must confirm the patient is using and benefiting from CPAP and CMS may request compliance data from the device to verify adherence. Additionally, attestation and an in-person visit are required for continuous glucose monitor (CGM) use. CMS requires follow-up visits every 6 months to maintain CGM coverage. The provider must document that the patient is adhering to use, continues to meet eligibility criteria, and is benefiting from the CGM. CMS may also request usage data from the CGM to verify compliance.

In a yet unpublished claims analysis of Traditional Medicare data commissioned by the Center, researchers find that 42.5% of RPM episodes exceed 6 months in length.⁹ Limiting the duration of RPM episodes to 6 months targets practices with lower value spending, while largely preserving payment for those practices already using RPM in more targeted, clinically appropriate ways.

CMS should also consider differentiating the payment rate for the first six months of monitoring for active management and control, from payment for longer-term monitoring and maintenance following a redetermination of medical necessity. ACCESS provides a useful model by distinguishing payment for initiation and active management from longer-term maintenance, whereas current fee-for-service remote monitoring payments do not.

Ensure similar, viable payment rates across fee-for-service and the ACCESS model

Observational Study. *Annals of Internal Medicine*. 2023;176(11):1465–1475.
<https://pubmed.ncbi.nlm.nih.gov/37931262/>.

⁸ Digital Hypertension Management Solutions. PHTI Health Technology Assessment. November 2024.
<https://phti.org/assessment/digital-hypertension-management-solutions/>

⁹ These unpublished findings are from a Peterson Center on Healthcare funded project conducted by researchers at Brown, Columbia, and the Hasso Plattner Institute. The results are also described in their independent public comment letter, which can be found at <https://www.regulations.gov/comment/CMS-2026-2377-9174>

There is a substantial gap between what Medicare pays to manage a patient with hypertension or diabetes through fee-for-service RPM (the two most prevalent primary diagnoses for the service) versus what Medicare will spend to manage the same patient through the ACCESS model (see Table 1). For example, for a Traditional Medicare beneficiary with diabetes, ACCESS could reimburse up to \$535 per year through ACCESS' Cardio-Kidney Metabolic track. Managing the same patient for a year through traditional RPM, CMS could reimburse up to \$1,774 in CY 2026. Neither rate is likely to represent the appropriate long-term payment level for these services—one being too high for too long, and the other being too low.

CMS should work to better align the payment rates across fee-for-service remote monitoring and ACCESS so that vendors are not incentivized to participate in fee-for-service simply because it pays more favorably than the ACCESS model. Payment rates must also be sufficiently viable to support the delivery of high-value care.

ACCESS' low reimbursement rates favor highly automated and AI-enabled tools capable of supporting large patient populations at a lower operating cost, which could improve scalability and affordability, but also disadvantages provider-led or service-intensive models that rely on clinicians or care teams—even when they produce meaningful clinical improvement or lower overall costs.

Fee-for-service reimbursement on the other hand, can go on indefinitely, even after a person's blood pressure or blood glucose have been under control for many months. The Center recently commissioned an analysis of Traditional Medicare claims data for RPM and RTM services from 2019-2025.¹⁰ The number of Traditional Medicare beneficiaries using RPM services (see Figure 1) and spending for RPM services have grown substantially since 2019 (see Figure 2). Total Medicare spending for RPM services would have been even higher, but the reimbursement rate for RPM codes has been decreasing over time, dampening the overall effect of increased utilization.

CMS' current proposed cuts to RPM and RTM reimbursement would begin phasing in in CY 2027, before going into full effect (see Table 1). Because a statutory [phase-in period](#) caps payment rate reductions at 19% in a calendar year, a full year of RPM would be reimbursed at \$1,612 in 2027 compared to \$866 when the cuts are fully implemented.¹¹

The Center believes that RPM spending under CY 2026 rates with a 6-month duration limit would be comparable to CMS' proposed total spending over 12 months under this current proposal (\$899 versus \$866). Introducing a 6-month duration limit would better capture RPM's value over the long term.

¹⁰ Peterson Center on Healthcare analysis of 100% traditional Medicare carrier claims (2019-2025) compiled by L&M Policy Research, based on data derived from the Chronic Conditions Warehouse (CCW).

¹¹ Centers for Medicare and Medicaid Services; CY 2027 Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B. Federal Register. July 16, 2026.

<https://www.federalregister.gov/documents/2026/07/16/2026-14327/medicare-and-medicaid-programs-cy-2027-payment-policies-under-the-physician-fee-schedule-and-other#p-140>

Figure 1: RPM Users, Traditional Medicare, 2019–2025

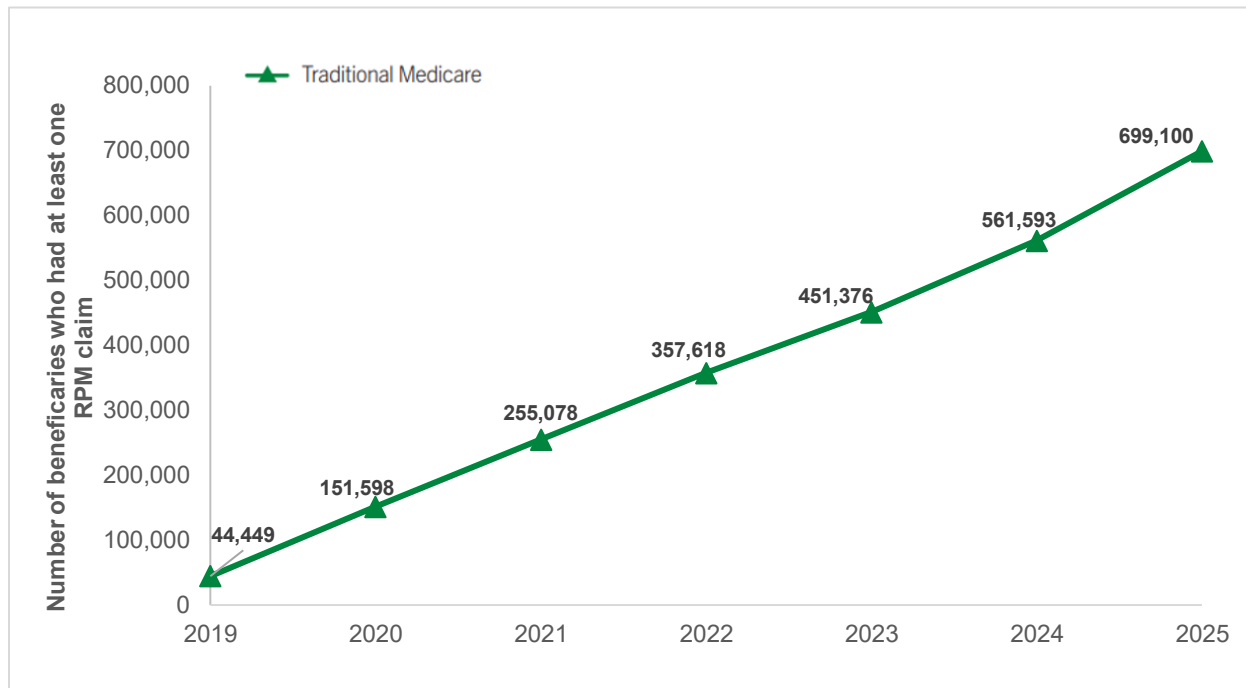


Figure 2: RPM Spending, Traditional Medicare, 2019–2025

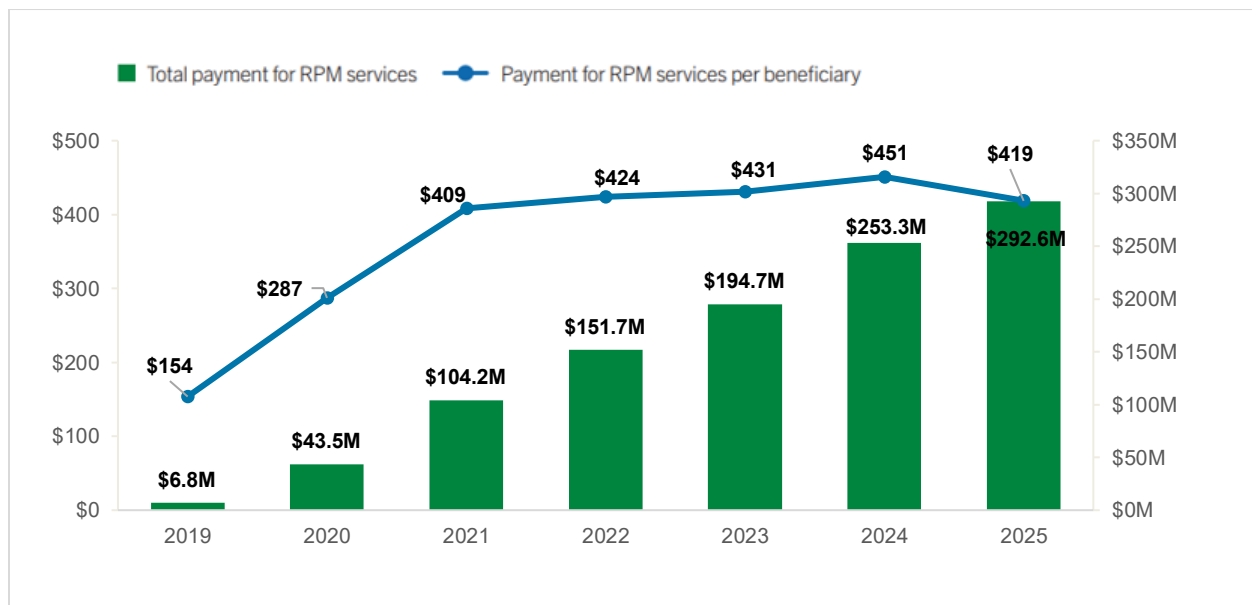


Table 1. Scenarios and Related Maximum Billing for Traditional Medicare Beneficiaries

Scenario	Max Billing Amount
RPM at 2026 rates (12-month duration)	\$1,774
RPM at 2026 rates (6-month duration)	\$899
RPM at new proposed rates fully implemented (12-month duration)	\$866
Full year ACCESS CKM track (diabetes) (12-month duration)	\$535
Full year ACCESS eCKM track (hypertension) (12-month duration)	\$475

Note: These prices were estimated using CY 2026 pricing and RVU data for the relevant codes. To model the fully implemented proposed rates, we used the QPP conversion factor and referred to the [proposed rule public use files](#) and [PFS relative value files](#). 99458 may technically be billed an unlimited number of times. For this analysis we assumed billing 99458 one time per month. For ACCESS we assume rural beneficiary add-on payment and the clinician co-management fee.

Require clinical outcomes reporting for RPM and RTM

CMS should phase in requirements for providers to report meaningful clinical outcomes for remote monitoring services, such as patient HbA1c or blood pressure. For chronic condition management where there are well-established clinical outcomes (e.g., Hypertension, Diabetes, etc.), these services should transition to an outcome-based payment model, such as ACCESS, regardless of if the service is delivered by a provider or a vendor.

Remote monitoring can improve outcomes for certain conditions, but CMS currently lacks even basic information to be sure of which conditions are being monitored for patients, what health data are being collected, and what outcomes providers seek to achieve. At minimum, CMS should require more specificity on remote monitoring claims and encounter submissions, including what physiological data are being collected (e.g., blood pressure, blood glucose) and what condition the RPM or RTM is being used to treat and monitor.

Outcomes reporting provides a glidepath to help providers transition out of fee-for-service and into outcome-based payment models. This could be operationalized in several ways. One option is using the CMS Innovation Center's ACCESS model as a framework. CMS could leverage ACCESS' required, standardized APIs. Alternatively, CMS could leverage existing billing and claims mechanisms in Traditional Medicare to collect outcome data for remote monitoring, where possible.

Ultimately, this reporting would allow CMS to understand what conditions are being treated, what physiologic data are being collected, and how services are being used. Such data are necessary to help payers evaluate the use of these solutions and help direct payment toward

higher-value use cases. This could also give CMS valuable real-world evidence to inform the development and expansion of future ACCESS tracks.

It is important to note that traditional providers play an important role in testing and validating new clinical applications outside of established chronic care. Before a vendor can scale an application in a tech-enabled, efficient manner, there must first be evidence that it works — and that evidence typically originates with traditional providers. To that end, there will be cases where remote monitoring services are delivered for conditions for which there are no well-established clinical outcomes. In such cases, CMS should consider a requirement that providers clearly document the specific reasons why a patient needs remote monitoring and the goal the provider is trying to achieve.

Create a pathway for traditional providers to participate in outcome-based payment models, as is the case today for vendors participating in the ACCESS model

In today's policy environment, traditional providers billing fee-for-service remote monitoring have no option to be paid based on outcomes at scale. CMS must ensure that traditional providers are able to participate in outcome-based payment models, such as ACCESS. The Center believes strongly that when a provider is using remote monitoring to manage chronic conditions with well-established clinical outcomes, these services should be paid based on outcomes.

CMS could develop this for traditional providers in several ways. One option is for the Agency to build a pathway for traditional providers into ACCESS. The ACCESS model offers strong outcomes accountability and creates opportunities for new entrants into the Medicare market, but its current participation requirements largely favor technology vendors over traditional providers. Another option is for CMS to build on the existing Medicare physician payment system, for example by expanding outcomes-reporting and accountability through MIPS Value Pathways (MVPs). CMS could use MVPs to expand collection of standardized, condition-specific clinical outcome measure data. This could be a scalable pathway for CMS to move traditional providers toward greater outcomes accountability and a bridge to a more modernized fee schedule.

Strengthen the ACCESS model

The ACCESS model marks an important milestone: the entry of Traditional Medicare as a major purchaser of clinical outcomes for chronic disease management, demonstrating broad recognition that payment should be based on results rather than services delivered. ACCESS's initial clinical tracks—behavioral health; musculoskeletal care; and cardio-kidney-metabolic conditions including diabetes, chronic kidney disease, and hypertension—and associated outcome measures [closely align with PHTI assessments](#).¹²

For ACCESS to realize its full potential, CMS must continue to evaluate and strengthen the model. This includes the need to calibrate reimbursement in a way that does not jeopardize high-value solutions in favor of those that can be most easily automated, even when they produce

¹² CMS's ACCESS Model in Context: Outcome-Based Payment for Health Technologies. Peterson Center on Healthcare. June 2026. <https://www.petersonhealthcare.org/news/cms-access-model-in-context/>

clinically superior outcomes (discussed above). In addition, CMS should consider the following recommendations to strengthen the ACCESS model:

Develop new ACCESS tracks where there are clinically validated outcome measures

CMS should continue to expand ACCESS beyond its four initial tracks to additional chronic conditions with validated outcome measures that can support the model's payment methodology. CMS has already [signaled](#) that it is considering new tracks for heart failure, substance use disorders, chronic obstructive pulmonary disease (COPD), and gastrointestinal (GI) conditions.¹³

PHTI's assessment of [virtual GI solutions](#) found that clinician-led solutions, including those that incorporate remote monitoring elements, improve symptoms and quality of life for patients while decreasing net spending.¹⁴ Tying payment for virtual GI solutions to incremental improvements in clinical outcomes or reductions in utilization may better reflect the value delivered by virtual GI solutions, which could be tested through the ACCESS model. More robust evidence generation will help clarify where virtual GI solutions deliver the greatest value, for which patients, for how long, and across which disease stages.

Recent analysis commissioned by the Center found that respiratory disorders, including COPD, accounted for approximately 4% of RPM episodes and 5% of RTM episodes in 2025. Heart failure constituted over 3% of RPM and 1% of RTM episodes.¹⁵ These conditions fall outside ACCESS's current tracks, but RPM and RTM use signal they may warrant consideration as future tracks.

Consider risk adjustment or sub-tracks for highly complex patients

The ACCESS model does not currently account for variation in patient complexity within each track. Beneficiaries with multiple comorbidities or higher acuity may require more intensive monitoring and clinical intervention to achieve the same outcomes as lower-risk patients, yet current payment structures don't necessarily reflect that difference in resource intensity. Without adequate risk adjustment — or dedicated sub-tracks for highly complex patients — participating organizations may face disincentives to enroll the beneficiaries who could benefit most from technology-enabled, outcome-based care. CMS should evaluate mechanisms, such as risk-adjusted payment rates or complexity-based sub-tracks, to ensure the model's incentives align with serving the full spectrum of patients.

Payment reform is imperative as AI fundamentally changes care delivery

PHTI convened three [workshops](#) on AI applications in healthcare across 2025 and 2026, bringing together senior leaders from health systems, medical societies, health plans, technology

¹³ Shiff J, Sutton A. Outcome-Aligned Payments for Technology-Enabled Care — A New CMS Approach to Paying for Chronic Disease Care in Medicare. *JAMA*. 2026;335(22):1932–1934. doi:10.1001/jama.2026.6659.

¹⁴ Virtual Gastrointestinal Care Solutions. PHTI Health Technology Assessment. March 2026.

<https://www.phti.org/wp-content/uploads/2026/05/PHTI-Virtual-GI-Care-Solutions-Assessment-Report-v1.1.pdf>

¹⁵ Peterson Center on Healthcare analysis of 100% traditional Medicare carrier claims (2019-2025) compiled by L&M Policy Research, based on data derived from the Chronic Conditions Warehouse (CCW).

companies, academia, investment firms, patient groups, and federal government agencies—including practicing clinicians.¹⁶ Our [latest report](#) unpacked how to approach payment for clinical applications of AI.¹⁷

AI is fundamentally different from previous health technologies. Over the next few years, AI will be technologically capable of diagnosing disease, managing chronic conditions, recommending treatments, and in some cases delivering care with limited to no human intervention. AI systems can operate continuously, asynchronously, and across large populations. By decoupling output from workforce size and capacity, it enables delivery of services at a scale that traditional labor-based models alone cannot reach.

Fee-for-service payment—today’s predominant payment model—was not designed for technologies that can independently perform clinical work that previously required human labor and expertise. If payment is tied primarily to the volume of activities performed, rather than the outcomes achieved, new technologies risk increasing the volume of billable services without a commensurate increase in clinical value.

Remote monitoring is particularly susceptible to this dynamic as AI-enabled tools make it increasingly easy to automate aspects of chronic condition monitoring and management. Companies that deliver remote monitoring, chronic care management, and other technology-enabled interventions are increasingly [embedding AI into their products](#).¹⁸ Capital is [following](#) with investments [concentrated among vendors building AI into workflows](#), signaling that AI will likely become core infrastructure for health technologies.^{19, 20}

The urgent challenge for CMS is to ensure AI creates value for patients and the healthcare system, instead of becoming an inflationary force. Outcome-based payment models, like ACCESS, represent a more sustainable way to pay for technology-enabled care. CMS must accelerate the transition of technology-enabled services toward outcome-based payment models as AI changes the underlying economics of healthcare delivery.

¹⁶ AI Applications in Healthcare. Peterson Health Technology Institute. Accessed September 1, 2026.

<https://www.phti.org/collaboration/ai-applications-in-healthcare/>.

¹⁷ Payment for Clinical AI. Peterson Health Technology Institute. July 2026. <https://www.phti.org/research-insight/payment-for-clinical-ai/>

¹⁸ Integrating AI and Telehealth: Remote Patient Monitoring. June 2026. https://telehealthcoe.org/wp-content/uploads/2026/06/AI-Telehealth-Brief-2-RPM-RTM_2026-06_f.pdf

¹⁹ Cadence Raises \$100M Series C Led by Spark Capital to Automate Chronic Care. Cadence. June 23, 2026. <https://www.cadence.care/post/cadence-raises-100m-series-c-led-by-spark-capital-to-automate-chronic-care>

²⁰ Q1 2026 Funding Overview: Capital Continues Concentrating and Four Other Market Signals. Rock Health. April 8, 2026. <https://rockhealth.com/insights/q1-2026-funding-overview-capital-continues-concentrating-and-four-other-market-signals/>

Request for Information: Redesigning Primary Care to Make America Healthy Again (section II.E.)

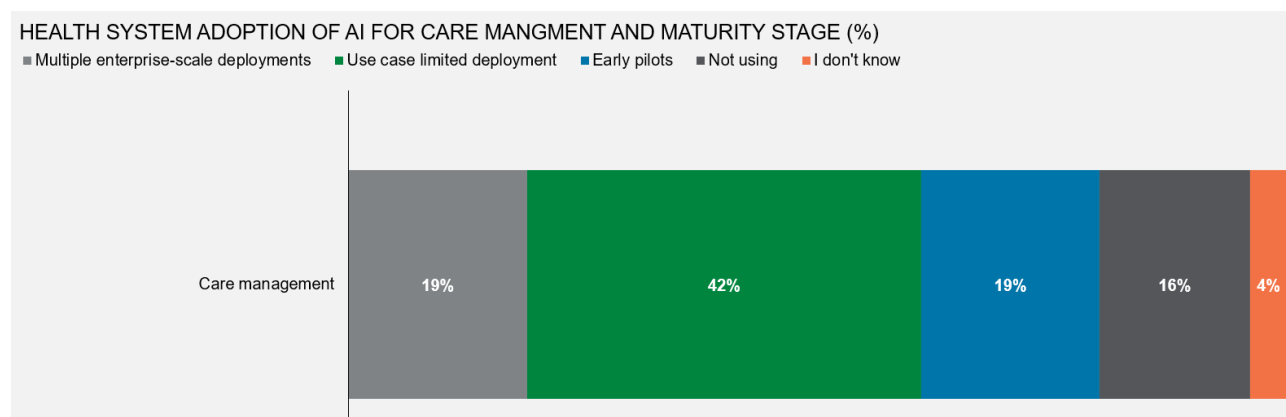
Care Management Code 'Family' (3)

CMS is considering reconfiguring the care management code 'family' to better establish effective payment options for care management services. The Agency is especially interested given changes in technology-enabled care models where patients may initially engage with digital tools or receive care entirely in a digital environment.

The Center commends CMS's attention to the valuation of care management codes. Care management is increasingly becoming technology-enabled. A growing number of [vendors](#) now market full-service care management and billing across CCM, PCM, and APCM codes—a trend that warrants further exploration as CMS considers the code family.²¹ As described above, companies that deliver remote monitoring, chronic care management, and other technology-enabled interventions are increasingly [embedding AI into their products](#), signaling that AI will likely become core infrastructure for health technologies.²²

A forthcoming finding in PHTI's 2026 State of Digital Health Purchasing survey indicates that over 60 percent of health systems have deployed AI for care management within their enterprise and an additional 19 percent are in early pilots (see Figure 3).²³ These findings suggest that AI-enabled care management is moving rapidly from experimentation toward broader adoption at scale.

Figure 3: Health System Adoption of AI for Care Management



²¹ See Lynk Health. Medicare Care Coordination Services. <https://lynk.health/ccm/>; Esrun Health. Chronic Care Management Services. <https://esrunhealth.com/chronic-care-management/>; KangarooHealth. Top Chronic Care Management Companies: Benefits & Features Compared. September 4, 2025. <https://www.kangaroohealth.com/blog/chronic-care-management-companies>.

²² Integrating AI and Telehealth: Remote Patient Monitoring. June 2026. https://telehealthcoe.org/wp-content/uploads/2026/06/AI-Telehealth-Brief-2-RPM-RTM_2026-06_f.pdf

²³ Forthcoming 2026 State of Digital Health Purchasing Survey. Peterson Health Technology Institute. <https://www.phti.org/>

To explore this further, the Center commissioned a new analysis of care management and remote monitoring codes for Traditional Medicare beneficiaries from 2019 to 2025 (see Table 2).²⁴

Findings from this analysis show:

- CCM utilization has grown steadily since 2019, from 975,000 to 1.7 million beneficiaries (9.6% annually), while spending grew from \$163 million to \$647 million (25.8% annually)—partly reflecting a 2022 RVU valuation increase. To qualify for CCM, beneficiaries must have at least two chronic conditions.
- Principal Care Management (PCM) shows the fastest growth, rising from 41,000 to 234,000 beneficiaries (78.5% average annual growth) and \$10 million to \$57 million in spending (77.1% average annual growth) since its introduction in 2022. To qualify for PCM, beneficiaries must have at least one chronic condition.
- Transitional Care Management (TCM), by contrast, has remained flat since 2019: 1.2 million to 1.3 million beneficiaries (0.6% annually) and spending from \$210 million to \$215 million (0.4% annually). TCM is for beneficiaries who have had an acute care discharge in the last 30 days.
- As of 2025, Advanced Primary Care Management (APCM) bundles CCM, PCM, and TCM services for patients with or without chronic conditions. In 2025, APCM was delivered to 440,000 beneficiaries and resulted in \$87 million in spending, showing that a bundled, non-time-based alternative payment can gain traction quickly.

Utilization and spending have grown substantially, especially for Chronic Care Management (CCM) (see Figure 4).²⁵ CCM alone was billed for 6% of Traditional Medicare beneficiaries in 2025 and has significant potential for further expansion, given the high prevalence of chronic disease among Medicare beneficiaries.^{26, 27} [Sixty-five percent](#) of Traditional Medicare beneficiaries have a diagnosis of hypertension alone and [two-thirds](#) have 2 or more chronic conditions.^{28,29} There are millions more patients whose treatment plan could include care management services than receive it today, regardless of whether these services improve clinical outcomes.

This is especially problematic as AI makes billing care management codes even easier and with fee-for-service reimbursement structures that allow perpetual billing. The current financial incentives put care management codes at risk of being inflationary without delivering commensurate, measurable value for Medicare beneficiaries. The Center recommends that CMS

²⁴ Peterson Center on Healthcare analysis of 100% traditional Medicare carrier claims (2019-2025) compiled by L&M Policy Research, based on data derived from the Chronic Conditions Warehouse (CCW).

²⁵ Ibid.

²⁶ Ibid.

²⁷ A Snapshot of Sources of Coverage Among Medicare Beneficiaries. KFF. <https://www.kff.org/medicare/a-snapshot-of-sources-of-coverage-among-medicare-beneficiaries/>

²⁸ Mapping Medicare Disparities by Population. Centers for Medicare & Medicaid Services. <https://data.cms.gov/tools/mapping-medicare-disparities-by-population>

²⁹ Connected Care Toolkit: Chronic Care Management Resources for Health Care Professionals and Communities. Centers for Medicare & Medicaid Services. <https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/connected-hcptoolkit.pdf>

assess the clinical and economic value of care management services and evolve reimbursement for these and other technology-enabled services toward greater outcome accountability.

Table 2: Utilization and Spending Across Care Management and Remote Monitoring Code Families, 2019-2025

Code Family	Years of Data	Utilization (beneficiaries)		Spending (\$ in Millions)	
		First Year to 2025	Average Annual Growth	First Year to 2025	Average Annual Growth
Care Management					
CCM	2019-2025	974,902 - 1,690,260	9.6%	\$163 - 647	25.8%
PCM	2022-2025	41,164 - 234,211	78.5%	\$10.2 - 56.7	77.1%
TCM	2019-2025	1,209,099 - 1,251,188	0.6%	\$209.6 - 215	0.4%
APCM	2025	442,997	N/A	\$86.5	N/A
Remote Monitoring					
RPM	2019-2025	44,449 - 699,100	58.3%	\$6.8 - 292.6	87.2%
RTM	2022-2025	15,694 - 146,158	110.4%	\$2.2 - 21.1	112.5%

Notes: CCM = chronic care management (99437, 99439, 99487, 99489, 99490, 99491), PCM = principal care management (99424, 99425, 99426, 99427), TCM = transitional care management (99495, 99496), APCM = advanced primary care management (G0556, G0557, G0558). RPM = remote physiologic monitoring (99453, 99454, 99457, 99458, 99091), RTM = remote therapeutic monitoring (98975, 98976, 98977, 98978, 98980, 98981). Spending figures rounded to the nearest hundred thousand.

Figure 4: Chronic Care Management (CCM) Spending, Traditional Medicare, 2019-2025

